Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARK PLAZA HOSPITAL
6514 MCNEIL DRIVE UNIT 1 STE 200
AUSTIN TX 78729

Carrier's Austin Representative Box
#01

MFDR Date Received
SEPTEMBER 3, 2008

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-09-0129-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated Taken From The *Table of Disputed Services* Dated September 3, 2008 : "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401 (c)(6)(A)(v)."

Requestor's Supplemental Position Summary Dated October 16, 2008: "Per your letter of October 16, 2008, enclosed please find a copy of all the medical records pertaining to the above matter."

Amount in Dispute: $7,403.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 23, 2008: "Respondent audited the charges accordingly and issued payment in the amount of $25,607.88. As shown in the EOBs, the charges were paid and the supply charges were denied in accordance with the Medical Fee Guidelines on a fair and reasonable basis. The Provider failed to supply invoices of costs to justify its billing fees. The auditing company has provided a cost breakdown of the fees associated with its reduction in charges. No additional reimbursement is owed. The Requestor failed to show that it should receive any additional reimbursement for the services provided. Respondent maintains that it paid a fair and reasonable rate for the services provided."

Respondent's Supplemental Position Summary Dated September 9, 2011: "Park Plaza Hospital has not demonstrated that the services they provided were, in fact, unusually costly and unusually extensive. Because of this, Park Plaza Hospital is not entitled to reimbursement under the Stop-Loss Exception."

Responses Submitted by: Harris & Harris

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 5, 2007 through September 10, 2007	Inpatient Hospital Services	$7,403.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 18 – Duplicate claim/service.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 105 – Additional information needed to review charges.
- W10 – Payment based on fair & reasonable methodology.
- W3-Additonal payment on appeal/reconsideration.
- 510-Payment determined.
- *-Original billed amount was for 8 units $4504.00, was denied on bill #1311753 and asked foor supply house invoice, no invoices on this current bill.
- * – Original billed amount $42,633.00 processed on bill #1311753. Second bill had billed amount of $44,269.40 now $44,014.90.
- 214 – 75% of Reasonable & Customary Charge.
- 211 – 50% of Reasonable & Customary Charge.
- 151 – Payment adjusted/undocumented services
- 304 – Submit Supply House Invoice for additional payment
- 16 – Not All Info Needed for Adjudication was Supplied
- 500 – Reimbursement amount based on U&C allowance
- * – Must have copy of actual supply house invoice showing cost of each implant unit billed.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.21.
2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in 28 Texas Administrative Code §134.401(c)(6). The requestor asserts in the position statement that "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401 (c)(6)(A)(v)." 28 Texas Administrative Code §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in 28 Texas Administrative Code §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to 28 Texas Administrative Code §134.1.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not

provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed $40,000 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401 (c)(6)(A)(v)."
   - The requestor does not discuss or explain how additional payment of $7,403.29 would result in a fair and reasonable reimbursement.
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/26/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.